

Intermountain Rural Electric Association and International Brotherhood of Electrical Workers, Local 111, AFL-CIO, CLC. Case 27-CA-11543

December 16, 1992

DECISION AND ORDER

BY CHAIRMAN STEPHENS AND MEMBERS OVIATT
AND RAUDABAUGH

On March 20, 1992, Administrative Law Judge James M. Kennedy issued the attached decision. The Respondent filed exceptions and a supporting brief, and the General Counsel and the Union filed briefs in support of the judge's decision and opposing the Respondent's exceptions.

The National Labor Relations Board has delegated its authority in this proceeding to a three-member panel.

The Board has considered the decision and the record in light of the exceptions and briefs and has decided to affirm the judge's rulings, findings, and conclusions only to the extent consistent with this Decision and Order.

In this case the judge found, consistent with the complaint allegations, that in the fall of 1990 the Respondent made an offer to the Union to pay the full amount of the pending annual increases in bargaining unit employees' medical and dental insurance premiums, that the Union accepted this offer, and that the Respondent subsequently repudiated their agreement in violation of Section 8(a)(5) and (1). The judge also found that the Respondent unlawfully deducted from the employees' paychecks amounts equivalent to these annual increases in insurance premiums. We find however, that there was no "meeting of the minds" sufficient to form an agreement between the Respondent and the Union in the fall of 1990 and therefore no unlawful repudiation. Accordingly, we reverse the judge's decision and dismiss the complaint in its entirety.

Facts

Some of the events and issues involved in a separate unfair labor practice proceeding between the parties are implicated in the arguments by the parties in this case, so we find it useful first to set out that factual background here. In *Intermountain Rural Electric Assn.*, 305 NLRB 783 (1991), it was alleged, inter alia, that in December 1988 the Respondent unlawfully failed to pay the annual medical and dental insurance premium increases required under the parties' expired collective-bargaining agreement while the parties were engaged in negotiations for a new overall agreement, and that instead the Respondent forced the bargaining unit employees to pay the premium increases by payroll deduction. It was further alleged that in March 1989 the

Respondent implemented its final bargaining offer, including a proposal for payment of medical and dental insurance premiums, without having reached a valid impasse in negotiations. The judge in that case, whose decision issued on October 10, 1990, concluded that the Respondent did not violate the Act by engaging in the unilateral changes set forth above. In its Decision and Order, *supra*, the Board reversed the judge's decision in significant part, finding that the Respondent's unilateral changes in terms and conditions of employment in fact violated Section 8(a)(5) and (1).

As reflected in the prior case, the parties traditionally aligned the duration of their collective-bargaining agreements with the health insurers' annual revisions of their programs and premium rates effective each December 1, thus allowing each new agreement to account for any rate changes. 305 NLRB 783, 784 fn. 3. As further reflected in that case, in 1988 the parties had been bargaining for a new collective-bargaining agreement to replace the one whose term ran from December 1, 1987, to November 30, 1988. Under article 27 of the 1987-1988 contract, the Respondent paid the full amount of medical and dental insurance premiums subject to certain conditions. With respect to medical premiums, the Respondent's "maximum contribution to any of the medical insurance plans in effect for its employees covered by this Agreement [was not to] exceed one hundred percent (100%) of the Blue Cross and Blue Shield Insurance Company premiums." With respect to dental insurance, the Respondent agreed to "pay one hundred percent (100%) of the premiums for the employees covered." *Id.* at 793. At the start of the 1988 negotiations, however, the Respondent proposed to pay specific maximum dollar amounts with respect to the new medical and dental insurance premiums, thereby replacing the "100%" language in the contract. The Respondent's initial offer was to pay specific dollar amounts constituting a partial contribution, with the bargaining unit employees responsible for the remainder. Eventually, the Respondent offered to pay, and implemented as part of its final proposal in March 1989, specific maximum dollar amounts which were sufficient to pay in full the cost of the new medical and dental premiums. The Respondent's proposal did not characterize these contributions as "100%." *Id.* at 793-794.¹ The Union maintained, at least from the time of the Respondent's first unilateral change in benefit payments in December 1988, that until the Respondent bargained in good faith to impasse on a new overall agreement, it was obligated to pay 100 percent of all medical and dental insurance premiums, including annual increases, under the terms of the agreement which expired November 30, 1988. *Id.* at 794.

The prior Decision and Order does not explicitly address events occurring between the parties after March

¹ See also R. Exh. 4 in the instant case.

1989. The instant case picks up roughly after that point, covering the parties' conduct with regard to the annual insurance premium increases in the fall of 1989 and, more significantly, in the fall of 1990. The events in this case took place while the previous proceeding was pending before the Board.

The Respondent, by its attorney, sent the Union a letter dated November 8, 1989, which stated in relevant part:

Intermountain Rural Electric Association has been notified by Blue Cross and Blue Shield of Colorado that the premiums for the health insurance programs offered by IREA to the members of the bargaining unit effective December 1, 1989 will be as follows:

<i>Employee Only</i>	<i>Employee Plus Dependents</i>
Blue Cross/Blue Shield	
\$154.55	\$417.53
HMO Colorado	
\$118.74	\$323.50

IREA proposes, effective December 1, 1989, to pay for members of the bargaining unit up to a maximum of Four Hundred Seventeen and 53/100 Dollars (\$417.53) per month toward the cost of the premium for family coverage in the medical insurance plan maintained and made available to the Association and One Hundred Fifty-Four and 55/100 Dollars (\$154.55) per month for single coverage toward the cost of the premium for single coverage in the medical insurance plan maintained and made available to the Association.

If you have any objections to the Association implementing this benefit for members of the bargaining unit effective December 1, 1989, please let me know. Otherwise, IREA will implement this benefit on December 1, 1989.

The Union, by its attorney, responded with a letter dated November 22, 1989, which stated in relevant part:

As you fully are aware, it is the position of the Union that the Company has not bargained in good faith to impasse with the Union and, therefore, it is not privileged to implement any of its bargaining proposals. The Union has taken that position consistently.

Additionally, it has been the Union's consistent position that because the Company has failed to bargain to good faith impasse with the Union it cannot make unilateral changes and, therefore, must adhere to the wages, hours, and other terms and conditions of employment set forth in the col-

lective bargaining agreement between Intermountain Rural Electric Association and IBEW Local 111 which agreement expired on November 30, 1988. While the agreement expired, Section 8(a)(5) of the National Labor Relations Act requires the Company to maintain the status quo prior to the expiration of that agreement until it bargains to good faith impasse with the Union.

The status quo with respect to medical and dental insurance is set forth in Article 27 at page 32 of that agreement. The agreement provides that with respect to health insurance, the Association will contribute 100% of the Blue Cross/Blue Shield Insurance Company premiums.

The Union does not consent to the Company's implementation of anything. Nevertheless, the Union has insisted and will insist that the Company pay 100% of the Blue Cross/Blue Shield Insurance Company premiums at all times and unless and until the Company bargains to a good faith and legal impasse with the Union.

The Respondent subsequently implemented its proposal of November 8, thus contributing specific dollar amounts covering all of the new medical insurance premiums. In a memorandum to employees concerning payment of the new premiums, the Respondent explained that the Union had been notified of the proposal and had not requested bargaining.

Subsequently, by letter dated August 8, 1990, the Respondent made the following proposal to the Union:

Intermountain Rural Electric Association has decided that since Christmas Eve falls on Monday, it will grant an additional holiday to its employees on December 24. This holiday will also be extended to the members of the bargaining unit.

If you have any objections to the Association's implementing this benefit for members of the bargaining unit, please let me know immediately.

The Union's response, by letter of August 13, 1990, stated in relevant part:

I am in receipt of your letter dated August 8, 1990, regarding the additional holiday of Christmas Eve, which falls on Monday, December 24th, that the Association wishes to extend to the members in the bargaining unit.

Please be advised, that by receipt of this letter, Local Union 111, International Brotherhood of Electrical Workers, acting as the exclusive bargaining agent, does so concur with the Association's implementation of this benefit for the employees in the bargaining unit.

With respect to medical insurance premium increases to be effective December 1, 1990, the Respond-

ent sent a letter dated October 8, 1990, to the Union, which stated in relevant part:

Intermountain Rural Electric Association has been notified by Blue Cross/Blue Shield of Colorado that the premiums for the health insurance programs offered by IREA to the members of the bargaining unit effective December 1, 1990, will be as follows:

<i>Employee Only</i>	<i>Employee Plus Dependents</i>
Blue Cross/Blue Shield	
\$164.13	\$443.42
HMO Colorado	
\$137.33	\$374.15

IREA proposes, effective December 1, 1990, to pay for members of the bargaining unit up to maximum of Four Hundred Forty-Three and 42/100 Dollars (\$443.42) per month toward the cost of the premium for family coverage in the medical insurance plan maintained and made available to the Association and One Hundred Thirty-Seven and 33/100 Dollars (\$137.33) per month for single coverage toward the cost of the premium for single coverage in the medical insurance plan maintained and made available to the Association.

If you have any objections to the Association implementing this benefit for members of the bargaining unit effective December 1, 1990, please let me know. Otherwise, IREA will implement this benefit on December 1, 1990.

The Union's response, dated October 12, 1990, stated in relevant part:

Our position with regard to your letter of October 8, 1990, is consistent with that stated in my letter of November 22, 1989. The Company has not bargained in good faith to impasse with the Union and is, therefore, not privileged to implement any of its bargaining proposals.

Since the Company has failed to bargain to good faith impasse with the Union, it cannot make unilateral changes and, therefore, must adhere to the wages, hours, and other terms and conditions of employment set forth in the collective bargaining agreement between IREA and IBEW 111 which agreement expired on November 30, 1988. While the agreement expired, § 8(a)(5) of the National Labor Relations Act requires the Company to maintain the status quo prior to the expiration of that agreement until it bargains to good faith impasse with the Union.

The status quo with respect to medical and dental insurance is set forth in Article 27 at page 32 of that agreement. The agreement provides that with respect to health insurance, the Association will contribute 100% of the Blue Cross/Blue Shield Insurance Company premiums.

The Union does not consent to the Company's implementation of anything. Nevertheless, the Union has insisted and will insist that the Company pay 100% of the Blue Cross/Blue Shield Insurance Company premiums at all times and unless and until the Company bargains to good faith and legal impasse with the Union.

In the meantime, the Respondent sent a letter dated October 11, 1990, to the Union correcting one of the dollar figures in its October 8 letter to reflect that the Respondent proposed to pay all the Blue Cross/Blue Shield individual premium. The letter also set forth the new rates for dental insurance premiums effective December 1, 1990, and proposed to pay specific dollar figures which would fully cover the cost of the new premiums. The letter finished with the same final paragraph as the October 8 letter, soliciting any objections that the Union might have to implementation of the proposal. The Union's October 29, 1990 response reaffirmed the Union's position in its October 12 letter, virtually repeating the final paragraph of that letter, as set forth above.

By memoranda of October 29 and November 1, 1990, the Respondent informed the unit employees that, because of the Union's refusal to consent to the Respondent's proposal to cover the pending increases in medical and dental premiums, the Respondent would maintain its current contributions, with the employees contributing the difference beginning December 1. The employees also were informed that their contributions would be made by payroll deduction unless they notified the Respondent (presumably to arrange an alternative payment method).

The Union replied to the Respondent's announcement to the unit employees by letter of November 16, 1990, which stated in relevant part:

I have received a memorandum from . . . IREA to all bargaining unit employees at IREA regarding payroll deductions dated November 1, 1990.

As I stated to you in my letters to you dated November 22, 1989, October 12, 1990, and October 29, 1990, the union will preserve its position in this matter that the company must pay all increases in health and dental premiums consistent with its obligation to maintain the status quo prior to the expiration of the most recent collective bargaining agreement between the parties.

We also know that the company disagrees with that position, and has solicited objections from the

union to the association's "implementation" of payment of the increased premiums for members of the bargaining unit.

Regardless of who is right, however, the increased premiums should be paid by the company. If the union is right, the company has no choice but to pay the increases. If the company is right, the union will not stand in the way of the premium increases being paid by the company. Such action by the union would be inconsistent with our position that the premium increases must be paid by the company anyway. Furthermore, in 1989, an identical exchange of correspondence between the company and the union resulted in agreement between the parties that the increases for that year would be paid, with the parties reserving their differing positions as to *why* the increases would be paid. The identical agreement was reached between the parties with identical correspondence in October of this year. Nevertheless, without informing the union of the same, the company this year decided to inform the employees directly that they would be subject to payroll deductions for this year's increases only.

Thus, our position is that the company *must* pay the increases and the union will take no action against the company if the increases are paid. If the increases for 1990 are not paid by the company, the union will take all legal action at its disposal against the company seeking payment of the 1990 increases by the company.

Subsequently, the Respondent carried out the program set forth to the unit employees in its October 29 and November 1 memoranda; there is no evidence concerning whether the parties discussed the means by which the unit employees would pay the increases in medical and dental insurance premiums.

Discussion

The complaint in this proceeding is narrowly drafted. Specifically, it alleges that the Respondent, by its letters of October 8 and 11, 1990, proposed to pay the full cost of the medical and dental insurance premiums which would be effective December 1, 1990, and that the Union, by its letters of October 12 and 29 and November 16, 1990, agreed to the Respondent's proposals, the parties thereby reaching "full and complete agreement." The complaint further alleges that the Respondent's failure and refusal "to implement and abide by the agreement" violated Section 8(a)(5) and (1).

The judge, after reviewing the background of litigation and the documents set forth above, reasoned that none of the Union's fall 1990 letters addressing the Respondent's offers could be seen as a rejection of the offers, and that the Union's November 16, 1990 letter in particular constituted an acceptance of the offers

sufficient to form an agreement. He concluded that the Respondent violated Section 8(a)(5) and (1) by its repudiation of the agreement and by its concomitant unilateral conduct in deducting unit employees' insurance contributions from their paychecks.² For the reasons that follow, we disagree with the judge.

The legal principles we apply are well settled. A collective-bargaining agreement is formed only after a "meeting of the minds" on all substantive issues and material terms of the contract. The question of contract formation is one based on the parties' expressed intentions regarding the terms of a collective-bargaining agreement, and this is true regardless whether a document has yet been signed. The General Counsel bears the burden of proving whether the requisite meeting of the minds has occurred. See generally *Kelly's Private Car Service*, 289 NLRB 30, 39-40 (1988), and cases cited there, *enfd.* 919 F.2d 839 (2d Cir. 1990). In determining whether an agreement has been reached, the Board uses general contract principles adapted to the context of collective bargaining, but it is not bound strictly by technical rules of contract law. See, e.g., *NLRB v. Electra-Food Machinery*, 621 F.2d 956 (9th Cir. 1980).

Our primary focus is on the correspondence exchange between the Respondent and the Union in October and November 1990, because it is this exchange that the complaint alleges, and the judge found, resulted in a "full and complete agreement" which the Respondent later repudiated. At first glance, although the Respondent characterized its October 8, 1990 letter as a "proposal," it appears that the exchange of correspondence reflects a trade of sharply differing legal views rather than an example of real collective-bargaining. In any event, taking the view of the contractual parties, the General Counsel, and the judge that this was a contractual negotiating scenario rather than merely an acrid exchange of legal points, ultimately the fact is that there was no meeting of the minds on all substantive issues between the parties.

A simple comparison of the parties' exchange of correspondence in August 1990 concerning an additional holiday benefit with the later fall 1990 exchange tends to confirm the lack of acceptance of the Respondent's subsequent premium payment proposal. Thus, in its August 13, 1990 letter answering the Respondent's August 8 proposal for the additional holiday and solicitation of "any objections," the Union stated that it "does so concur with the Association's implementation of this benefit." No one would dispute that this exchange reflected an offer and an acceptance leading to an agreement on a term and condition of employment. In the later fall exchange, however, in reply to the Respondent's October 8 and 11 proposals

²The judge found it unnecessary to reach the General Counsel's alternative estoppel theories.

to implement full payment of the new medical and dental insurance premiums and solicitation of “any objections,” the Union’s October 12 and 29 letters stated that it “does not consent to the Company’s implementation of anything.” The lack of anything resembling an acceptance here is fairly obvious considered by itself, and even more so in comparison with the August exchange. It also appears that the Respondent perceived that there was no “meeting of the minds,” in view of its contemporaneous announcement to employees referring to the Union’s refusal to consent to the Respondent’s proposal.

Most significantly, we are satisfied that the parties understood, after the fall 1990 correspondence was exchanged, that the Respondent’s proposal to pay specific maximum dollar amounts with respect to the insurance premiums was consistent with the position it had taken in the 1988 negotiations, with the nature of its unilateral implementation in March 1989 concerning insurance premiums payments, and with the proposal it had made in the fall of 1989. The expired 1987–1988 collective-bargaining agreement called for the Respondent to pay “100%” of the insurance premiums, and it was always arguable, at the least, that this comprehended an open-ended obligation to pay the annual increases automatically.³ The Respondent’s consistent desire from the 1988 negotiations forward was to move away from the “100%” concept of payment to a payment of specific maximum dollar amounts. This is reflected in its fall 1990 proposals to pay specific dollar amounts, even though they in fact represented payment of the full cost—100 percent—of the new medical and dental premiums.

Similarly clear to the parties throughout the correspondence exchanged in the fall of 1990, was that the Union’s position was consistent with the position it had been taking since December 1988, i.e., that the Respondent was obligated under the expired contract to pay 100 percent of the insurance premiums regardless of the annual increases as long as the Respondent failed to bargain in good faith to impasse regarding an overall collective-bargaining agreement to replace the expired one. Correlatively, its consistent response to the Respondent’s proposal to implement payments based on specific dollar amounts—in place of an acknowledgment of its continuing “100%” obligation—was to reject the proposal out of hand.

The difference between the Respondent’s proposal—setting forth the obligation it was willing to incur—and the Union’s response—setting forth its view of the Respondent’s preexisting obligation—is both stark and substantive. Although under both the Respondent’s proposal and the Union’s response the Respondent would be required to pay the new annual insurance

premiums in full, material and substantive differences in the effect of the two theories of payment are evident. For example, if the Union had agreed in full to the Respondent’s proposal, the agreement conceivably would have terminated the Respondent’s contested obligation under the expired contract to pay “100%” of the medical and dental insurance premiums. Relatedly, such an agreement would have set a concrete maximum dollar standard marking the Respondent’s obligation to pay, which would not automatically expand with the insurance companies’ next annual premium increases.

The steadfastness with which each party held to its own view of the proper basis for insurance premium payments further establishes the material and substantive nature of their disagreement. Consequently there was no “meeting of the minds” and the parties failed to reach a full and complete agreement. The Union’s November 16, 1990 letter, far from establishing the Union’s acceptance of the Respondent’s offers, traces the depth of the chasm between the parties concerning this issue. Thus, although the Union agreed that the Respondent should pay the full amount of the new premiums, it clearly set out the parties’ continuing disagreement regarding the proper theory supporting the Respondent’s payment obligation. In short, in this letter as before, the Union did not accept the Respondent’s proposal; it merely reminded the Respondent of its Section 8(d) status quo obligation, extant from December 1988, as the Union perceived it.

Our conclusion that no agreement was formed in the fall of 1990 is not undermined by the fact that the parties engaged in an exchange of correspondence in the fall of 1989 almost identical to that which gave rise to the underlying complaint. We are mindful that the 1989 exchange was followed by the Respondent’s payment of the full insurance premiums. Although such payment may lead one to surmise, as the Union did in its November 16, 1990 letter, that an agreement had been reached in 1989, the evidence is simply not adequate to establish that the Respondent’s conduct in paying the full premiums that year was based on a sufficient “meeting of the minds.” On this record, it is at least as likely that the Respondent acted pursuant to a unilateral decision in the fall of 1989 to implement its proposal in the face of the Union’s adamant refusal to “consent to the implementation of anything.”⁴ In 1989 as in 1990, it is evident that the parties did not agree whether the obligation to pay the new insurance premiums should emanate from the Respondent’s offer to pay specific dollar amounts or from a perceived, preexisting duty under the expired collective-bargaining agreement to pay 100 percent of whatever the pre-

³ The Board in fact found this interpretation of the contractual language to be the appropriate one. 305 NLRB 783, 784.

⁴ Whether the Respondent’s conduct in the fall of 1989 was unlawful is not before us. Further, we note that the judge did not determine whether the parties reached an agreement in the fall of 1989.

miums were. Therefore, the parties' previous conduct and the Respondent's ambiguous implementation in December 1989 does not tend to show that there was in fact an agreement in the fall of 1990.

Accordingly, we reverse the judge's conclusion that the Respondent unlawfully repudiated an agreement to cover the costs of the unit employees' new medical and dental insurance premiums in the fall of 1990, because we conclude that the parties did not achieve a meeting of the minds on all substantive, material terms, and therefore, no agreement was reached.

The General Counsel and the Union both have contended that, should it not be found that the Respondent and the Union reached an actual agreement in the fall of 1990, then common law principles of estoppel—either promissory or equitable—require that the Respondent be ordered to cover the full cost of the new insurance premiums effective December 1, 1990. Although it is not entirely clear from their contentions which theory of estoppel we are invited to apply, ultimately it does not matter because we find the circumstances inappropriate for application of either theory. First and foremost, even if the facts of this case fit the elements for an equitable conclusion that the Respondent should be ordered to pay the full cost of the insurance premiums, Section 8(d) and the Supreme Court's decision in *H. K. Porter Co. v. NLRB*, 397 U.S. 99 (1970), would likely preclude us from entering an order compelling an agreement where the parties themselves were unable to reach one. See also *Operating Engineers Local 30 (Hyatt Management)*, 280 NLRB 205 (1986), petition for review denied sub nom. *Hyatt Management Corp. v. NLRB*, 817 F.2d 140 (D.C. Cir. 1987).

Assuming, arguendo, that it is appropriate in this case to address the promissory estoppel theory advanced by the General Counsel, we would still conclude that the situation does not merit such a remedy.⁵ *Black's Law Dictionary*, 1093 (5th ed. 1979), defines promissory estoppel as:

That which arises when there is a promise which promisor should reasonably expect to induce action or forbearance of a definite and substantial character on part of promisee, and which does induce such action or forbearance, and such promise is binding if injustice can be avoided only by enforcement of promise. "*Moore*" *Burger, Inc. v. Phillips Petroleum Co., Tex.*, 492 S.W. 2d 934.

It is reasonably inferable that the "action or forbearance" which the Respondent, as promisor, expected to induce from the Union, as promisee, was an agreement with the Respondent's proposals in the fall of 1990 for

specific dollar amount payments of insurance premiums, distinct from the "100%" language of the expired collective-bargaining agreement. The Union in fact was not so induced, i.e., the Union clearly did not agree to the "specific dollar amount" theory of the Respondent's proposal. In the absence of this induced action, promissory estoppel is not applicable.⁶

Further assuming, arguendo, that it is appropriate here to address an equitable estoppel theory, as the Union appears to suggest by arguing that the parties' fall 1989 conduct sheds light on their fall 1990 conduct, we similarly conclude that the circumstances do not warrant this kind of remedy.⁷ Thus, the Union contends that the fall of 1989 exchange of correspondence followed by the Respondent's implementation of its proposal led the Union to believe that the parties had reached an agreement, and it further contends that it relied in good faith on this past conduct in responding similarly to the Respondent's similar proposal in the fall of 1990. This contention implicitly depends on the assumption that the Union's November 22, 1989 response—refusing to "consent to the Company's implementation of anything"—represented, objectively, an acceptance of the Respondent's proposal. We think this assumption unreasonable. As we stated above, the Respondent's decision to implement in December 1989 appears ambiguous at best on this record; it was not clear whether the implementation was based on an "agreement" or a unilateral decision. The Union did not lack the means to clarify the situation at that time, i.e., to seek from the Respondent an explanation of the basis for its implementation. Further, because of this ambiguity, the Company's fall 1989 conduct was not so misleading that the Union could reasonably rely on it in the fall 1990 exchange.

A critical factor in our contractual analysis above, as well as implicitly in our estoppel analyses, is the Union's consistent position in the circumstances of this case that the Respondent was obligated under the expired 1987–1988 agreement and Section 8(d) to pay 100 percent of the insurance premiums, regardless of annual increases, until it bargained in good faith to impasse with the Union. Although that position is consistent with the Board's rationale in the previous proceeding between these parties, we find that regardless of the merits of this position, it goes beyond the nar-

⁶To the extent that the General Counsel contends that what the Respondent sought to induce was merely the Union's forbearance from objecting to the Respondent's proposal, the contention still misses the mark. It is clear that the Union substantially objected to the proposal.

⁷The Board has recognized the following elements of equitable estoppel: (1) lack of knowledge and the means to obtain knowledge of the true facts; (2) good-faith reliance on the misleading conduct of the party to be estopped; and (3) detriment or prejudice from such reliance. See, e.g., *Century Wine & Spirits*, 304 NLRB 338 fn. 13 (1991).

⁵The Board previously has recognized the potential applicability of the theory of promissory estoppel in a collective-bargaining context. See *Sonat Marine*, 281 NLRB 87, 93–94 (1986).

row scope of the complaint in this case; viz, whether the parties reached agreement in the fall of 1990. Our decision here that there was no such agreement reflects no more than the constraints imposed by the complaint. We do not intend, nor should our decision be interpreted as having, any effect on the Board's Decision and Order at 305 NLRB 783.⁸

ORDER

The complaint is dismissed.

⁸The judge found that the Respondent's unilateral payroll deductions from unit employees' wages was also unlawful. We note that the Respondent contends that this conduct was neither alleged as unlawful nor litigated. In light of our dismissal of the 8(a)(5) repudiation allegation—the sole allegation of unlawful conduct in the complaint—there is no independent support for an unlawful unilateral change theory in this case, premised as it was on the existence of the parties' purported agreement in the fall of 1990. Whether the Respondent, however, is required to maintain 100 percent coverage premised on the terms of the expired 1987–1988 collective-bargaining agreement is a matter to be resolved in the compliance stage of the above-referenced Board Decision and Order.

Donald E. Chavez, for the General Counsel.
Martin Semple and *Patrick Mooney* (*Semple & Jackson*), of Denver, Colorado, for the Respondent.
Joseph M. Goldhammer (*Brauer, Buescher, Valentine, Goldhammer & Kelman*), of Denver, Colorado, for the Charging Party.

DECISION

STATEMENT OF THE CASE

JAMES M. KENNEDY, Administrative Law Judge. This case was tried before me in Denver, Colorado, on October 29, 1991, upon a complaint issued by the Regional Director for Region 27 of the National Labor Relations Board on January 11, 1991. The complaint is based upon a charge filed by International Brotherhood of Electrical Workers, Local 111, AFL–CIO, CLC (the Union) on December 28, 1990. It alleges that Intermountain Rural Electric Association (Respondent) has committed certain violations of Section 8(a)(5) and (1) of the National Labor Relations Act (the Act).

Issues

The only issue which is presented here is whether or not Respondent was privileged to decline to pay an increase in the medical and dental insurance premiums beginning December 1, 1990. The General Counsel asserts that it was obligated to do so by virtue of an actual agreement which Respondent has disavowed; Respondent asserts it simply made an offer which the Union rejected.

Alternatively, the General Counsel contends that the doctrine of equitable estoppel requires Respondent to pay the amounts in question.

The parties were given full opportunity to participate, to introduce relevant evidence, to examine and cross-examine witnesses, to argue orally, and to file briefs. The General Counsel and Respondent have both filed briefs which have been carefully considered. Based upon the entire record of

the case, as well as my observation of the witnesses and their demeanor, I make the following

FINDINGS OF FACT

I. JURISDICTION

Respondent is a public utility engaged in the supply and transmission of electrical power with a principal office located in Sedalia, Colorado. It annually derives gross revenue in excess of \$250,000 and each year sells services to Colorado enterprises which are directly engaged in interstate commerce valued in excess of \$50,000; additionally, it annually purchases and receives goods, materials, and services valued in excess of \$50,000 from sources and points outside Colorado. Accordingly, Respondent admits and I find it to be, an employer engaged in commerce within the meaning of Section 2(2), (6), and (7) of the Act.

II. LABOR ORGANIZATION

Respondent admits the Union is a labor organization within the meaning of Section 2(5) of the Act.

III. ALLEGED UNFAIR LABOR PRACTICES

Background

The Union represents Respondent's production and maintenance employees at Sedalia, Strasburg, Woodland Park, and Conifer, Colorado. The most recent collective-bargaining contract was from December 1, 1987, through November 30, 1988. Since that time the parties have been without a contract and certain litigation before the Board has occurred, resulting in a hearing before Administrative Law Judge William J. Pannier III and review by the Board. That proceeding involved, inter alia, the question of whether a valid impasse had occurred privileging Respondent to make certain unilateral changes including declining to pay a health insurance premium increase and transferring the cost of that increase to the employees. Judge Pannier found in Respondent's favor, but the Board reversed.¹ It held, with respect to the health insurance issue, that Respondent was not privileged to pass the premium increases on to the employees and that Respondent had failed to bargain over the issue by simply announcing it to the Union as a fait accompli. It further held that the Union had not waived the right to bargain over that change.

The matters under scrutiny in the case before Judge Pannier involved conduct occurring in late 1988 and early 1989. In the case at bar, we are focusing on matters which occurred toward the end of 1990. Both proceedings have arisen because of certain language in the expired collective-bargaining agreement. The parties have disagreed for several years regarding how that language is to be interpreted as it applies to the annual premium increases. Part of the problem arises from a disagreement regarding whether or not a legitimate impasse occurred in 1988–1989 privileging the unilateral changes, as litigated earlier. Part of it stems from the parties' differing perceptions dealing with what their respective duties are toward one another. For whatever reason, the parties seem unwilling to talk to each other about problems which

¹ *Intermountain Rural Electric Assn.*, 305 NLRB 783 (1991). (Cases 27–CA–10711, 27–CA–10711–3, and 27–CA–10890.)

occur. That is unfortunate, because these problems are not insurmountable and the only injured persons are the employees who, as the facts will demonstrate, are being held hostage by each party.

As Judge Pannier pointed out in his decision, the collective-bargaining contracts over the years have provided that the employees will be covered by a Blue Cross/Blue Shield health plan. The Board and Judge Pannier both observed that each year that insurance company adjusts its premiums effective December 1. To account for that expectancy, the parties' collective-bargaining contracts have been only for 1 year and have had expiration dates allowing for sufficient time to accommodate the changed premium rates. Until 1988 the parties had always reached a new contract shortly after the new insurance rates became known.

In late 1989, when the new rates for 1990 were set, no unfair labor practice charges were filed over Respondent's handling of the new rates. Nonetheless, the parties became involved in a theory imbroglio over how it should be analyzed and handled. That squabble over theory resulted in the instant litigation when the 1991 rates were announced.

The Evidence

Article 27 of the expired collective-bargaining contract contains the following language:

A. [Respondent] agrees to keep in full force and effect during the term of this Agreement the medical insurance coverage currently in effect for its permanent, full-time employees covered by this Agreement. However, [Respondent] reserves the right to change insurance carriers during the term of this Agreement provided the new insurance coverage is substantially the same as the existing coverage.

B. [Respondent's] maximum contribution to any of the medical insurance plans in effect for its employees covered by this Agreement shall not exceed one hundred percent (100%) of the Blue Cross and Blue Shield Insurance Company premiums. Employees eligible for any individual medical plan insurance shall not have a contribution made by [Respondent] for their benefit to any medical insurance plan in excess of the Blue Cross and Blue Shield Insurance Company premium for individual medical insurance. Employees eligible for family plan medical insurance shall not have a contribution made by [Respondent] for their benefit to any medical insurance plan in excess of the premium for Blue Cross and Blue Shield Insurance Company Family Plan Medical Insurance.

C. [Respondent] will keep in full force and effect during the term of this Agreement the Delta Dental Plan of Colorado for its permanent, full-time employees. [Respondent] will pay one hundred percent (100%) of the premiums for the employees covered by this agreement. However, [Respondent] retains the right to change the dental insurance carrier during the term of this Agreement.

In November 1989, a year before the complaint's concern, Respondent dealt with the annual Blue Cross/Blue Shield premium increase by notifying the Union of the increase. By letter dated November 8, Respondent's attorney, Martin

Simple, advised the Union's business manager, John Davis, of the increases and presented a short chart describing them. In his letter, he said: "[Respondent] proposes, effective December 1, 1989, to pay for members of the bargaining unit up to a maximum of [same figure as listed in the chart] . . . If you have any objections to [Respondent] implementing this benefit for members of the bargaining unit effective December 1, 1989, please let me know. Otherwise [Respondent] will implement this benefit on [that date]."

Simple's letter triggered the following response from the Union's attorney, Joseph Goldhammer: "[I]t is the position of the Union that the Company has not bargained in good faith to impasse with the Union and, therefore, must adhere to the wages, hours and other terms and conditions of employment set forth [in the expired collective bargaining agreement]. While the agreement expired, Section 8(a)(5) of the [Act] requires the Company to maintain the status quo The status quo with respect to the medical and dental insurance is set forth in [the above-quoted article of the collective bargaining agreement]. The agreement provides that with respect to health insurance, [Respondent] will contribute 100% of the Blue Cross/Blue Shield Insurance Company premiums The Union does not consent to the Company's implementation of anything. Nevertheless, the Union has insisted and will insist that the Company pay 100% of the Blue Cross/Blue Shield Insurance Company premiums at all times unless and until the Company bargains to a good faith and legal impasse with the Union."

Respondent thereupon implemented the payment of the new, increased premiums. In its memo to employees explaining the increased premium payment, its assistant general manager, John Pope, asserted that it was doing so because the Union, after having been advised of the proposal, had not requested bargaining over it.

In August, Simple wrote Davis to advise him that Respondent proposed an additional paid holiday on Christmas Eve since it fell on a Monday that year. He again asked to be advised if the Union had any objection. Five days later, Davis advised that he "concur[red] with [Respondent's] implementation of this benefit."

It is the following evidence which is the factual predicate for the complaint. On October 8, 1990, Simple again advised the Union, via a letter and chart virtually identical to the 1988 notice, of the new premium rates. Again using "proposal" language, he said Respondent wished to pay the amount called for by the preceding chart. As before, he asked Davis to advise him if he had any objections to the new premium payments being paid on behalf of bargaining unit members for, if not, Respondent would begin paying those amounts on their behalf as of December 1, 1990. [There followed some correspondence from Simple dated October 11, 1990, relating to a correction of one of the figures and a notice of increase in the dental premiums].

Again Goldhammer responded. In his letter of October 12, 1990, he said: "Our position with regard to your letter of October 8, 1990 is consistent with that stated in my letter of November 22, 1989 [recited supra]. The Company has not bargained in good faith to impasse with the Union and is, therefore, not privileged to implement any of its bargaining proposals Since the Company has failed to bargain to good faith impasse with the Union, it cannot make unilateral changes and, therefore, must adhere to the wages, hours and

other terms and conditions of employment set forth [in the expired collective bargaining agreement]. While the agreement expired, Section 8(a)(5) of the [Act] requires the Company to maintain the status quo prior to the expiration of that agreement until it bargains to good faith impasse with the Union The status quo with respect to the medical and dental insurance is set forth in [above quoted article of the collective bargaining agreement]. The agreement provides that with respect to health insurance, [Respondent] will contribute 100% of the Blue Cross/Blue Shield Insurance Company premiums."

As in his 1989 letter, Goldhammer concluded with: "*The Union does not consent to the Company's implementation of anything.* Nevertheless, the Union has insisted and will insist that the Company pay 100% of the Blue Cross/Blue Shield Insurance Company premiums at all times unless and until the Company bargains to a good faith and legal impasse with the Union." [Emphasis added.]

Subsequently, on October 29, 1990, Goldhammer responded to the October 11 letter correcting one of the figures and announcing the dental premium hike. He concluded that letter with: "I will, then, simply reiterate that the Union does not consent to the Company's implementation of anything. . . . [and repeats his contention that Respondent is obligated to pay 100% of the premiums]."

Also on October 29, Karen Evans, Respondent's assistant to the general manager and manager of human resources, wrote a memo to the employees. It begins with an assertion that a memo from Davis to the employees (which is not in evidence) demanded a response. She first argued that Davis was incorrect regarding who was responsible for the absence of a wage increase saying the Union was to blame, not the Company. She then turned to the health and dental insurance matters and quoted Goldhammer's October 12 letter, arguing it was a Union admission that it had blocked such increases. She quotes Goldhammer's statement that "the Union does not consent to the Company's implementation of anything" and ended saying, because of the Union's position, "[Respondent] can only continue to pay the current contributions for health and dental insurance . . . and you will pay the difference The Personnel Department plans to provide for the appropriate payroll deduction unless you notify them immediately."

On November 1, 1990, Evans advised each employee what his or her payroll deduction would be and notified them that the deduction would be taken from their 20th of the month paycheck beginning in December.

On November 1, 1990, Davis responded with a memo of his own, which attempted to put the previous correspondence in what he deemed to be the proper perspective. He accuses Respondent of selective quotation and refers to the fact that Judge Pannier's decision had been appealed.

On November 16, 1990, Goldhammer wrote Semple a letter acknowledging that the Union and Respondent have a disagreement over the meaning of the collective-bargaining contract's language (whether it provided for a ceiling on the size of the premium as Respondent contends or for full coverage no matter what the premium, as the Union contends). In an apparent effort to ameliorate their differences, Goldhammer said:

Regardless of who is right, . . . the increased premiums should be paid by the company. If the union is right, the company has no choice but to pay the increases. *If the company is right, the union will not stand in the way of the premium increases being paid by the company.* Such action by the union would be inconsistent with our position that the premium increases must be paid by the company anyway." [Emphasis added.]

He said the correspondence the previous year had resulted in an agreement that the higher premiums be paid, with the parties reserving their respective positions regarding why they should be paid. He claimed a similar agreement had been reached in October 1990, but that Respondent had gone directly to the employees to advise them that they would have to shoulder the increase. He concluded:

[O]ur position is that the company *must* pay the increases and the union will take no action against the company if the increases are paid. [He goes on to say if Respondent does not pay, the Union will take legal action to obtain payment; underscore in original.]

Up to the date of the hearing, Respondent had continued to decline to make the payments in full, requiring the employees to make up the difference. Moreover, it never sought to discuss with the Union the means by which the increases would be paid, whether by payroll deduction or by independent payment.

IV. ANALYSIS AND CONCLUSIONS

If one were to look for the reasons for this dispute, without any concern for complying with one's duty under the law, there is blame which can be assigned to each party. Moreover, both messengers Semple and Goldhammer can rightly be faulted for petty posturing. This entire dispute has elements suggesting it is both contrived and artificial. The employees in question face real and difficult health coverage concerns, yet both lawyers, in the guise of concern for those employees' well-being, are playing a game of chicken, each trying to force the other off the road. That attitude does not speak well for either of them.

My job, however, is to perform a factual analysis and apply the appropriate law. In this instance, I conclude that the General Counsel has demonstrated that Respondent has entered into and reneged upon an agreement to pay the full amount of the premiums which it offered on October 8 (as corrected and expanded upon on October 11), 1990. In that letter, Respondent advised the Union of the premium payments it intended to make. That offer did not require the employees to contribute to the payment of any premiums, either the medical insurance or the dental. Furthermore, that offer was never withdrawn. The only thing which happened was Goldhammer's immoderate remarks that the Union was not "consenting" to anything which Respondent chose to do.

I agree with Respondent that Goldhammer's words could be read as a rejection of the bargaining obligation and therefore a rejection of an offer. It could also be interpreted as an angry waiver of the right to bargain and an authorization for Respondent to proceed. Yet, in context, it was neither. Instead, it was a testy statement that the Union would not, because it was concerned with remedying what it believed to be previous unfair labor practices, waive its statutory right to

bargain over unilateral changes. Semple knew that; it had been the center of litigation before Judge Pannier.

Moreover, as a practical matter, Respondent had no intention of depriving the employees of health coverage. If it had, it would not have made the offer it did. The entire scenario, as Semple readily saw, provided Respondent with an opportunity to take a free shot at the Union. It was prepared to pay the full premium amounts and could afford to do so. At the same time, it was undergoing litigation and having communication problems with the Union. By blaming the Union for the wage deductions, Respondent knew it would lose nothing financially, but might sting the Union in a way which would cause it severe internal discomfort. Conceivably, it might even result in membership disaffection. And, even if Respondent lost any ensuing litigation over the matter, it didn't affect the budget one way or another. If ordered to make the employees whole for premiums they shouldn't have had to pay, the money was always there and Respondent was always prepared to pay it. The whole battle could have been avoided had Goldhammer simply replied, as Davis had with the Christmas Eve proposal, that the Union had no objections. Instead, he provided Semple with a chain, and Semple yanked it.

Even so, Goldhammer's comments were not a directive to Respondent to not implement the proposal. When he learned Respondent was treating his response as a rejection, he quickly, and timely, corrected any misapprehension Respondent may legitimately have had. His letter of November 16, 1990, clearly advised Respondent that it was free to implement its proposal. He said, "[T]he union will not stand in the way of the premium increases" previously proposed by Respondent. He even went on to say the Union would take no action against Respondent if it paid those moneys. His letter was more than a month before the December 20 paycheck, the first in which payroll deductions were to be taken.

Moreover, taking Respondent's "offer" language at face value,² Goldhammer's letter can reasonably be seen as an acceptance of an unwithdrawn offer. Indeed, none of Goldhammer's letters can be seen as a rejection of that offer. Therefore, Respondent's argument that the offer was with-

²Frankly, I have difficulty in perceiving Respondent's so-called "offer" as a legitimate bargaining proposal. Sec. 8(d) of the Act, upon the contract's expiration, had set the levels of wages, hours and conditions of employment for the employees, including the levels of health and dental insurance coverage. It did not set the price for those benefits. Respondent's only duty, therefore, was either to maintain the levels of coverage or propose changes in them. Its cost to either maintain or change those levels of coverage was therefore not a mandatory subject of bargaining which it was obligated to propose to the Union when the insurance companies increased their billings. It is, instead, only a business overhead matter. Of course the price of insurance might become a topic to be discussed at the bargaining table if wages became an issue and the parties were forced to allocate between wages and fringe benefits, but standing alone it is nothing more than a business expense.

In a sense therefore, Respondent's "offer" may be seen as an attempt to hurry the Union simply by bringing the subject to its attention. Clearly Respondent's price for insurance was of very little interest to the Union. It had no ability to influence it through the collective-bargaining process. Therefore, it had no counterproposal to make and Semple knew it. The Union's replies to Respondent's bait were unfortunate and it fell into Respondent's trap of engaging in an unnecessary word war.

drawn by the Union's act of declination is rejected. Moreover, the Board, affirmed by the circuit courts of appeal, has frequently held that that particular rule of contract law is not usually applicable in cases arising under the Act. *Pepsi-Cola Bottling Co. of Mason City v. NLRB*, 659 F.2d 87, 89 (8th Cir. 1981), vacated on other grounds 466 U.S. 901 (1984); *Presto Casting Co. v. NLRB*, 708 F.2d 495, 497 (9th Cir. 1983); *Georgia Kraft Co. v. NLRB*, 696 F.2d 931, 937-938 (11th Cir. 1983). Respondent, therefore, has no valid justification for refusing to honor its own commitment. Accordingly, I find that refusal to be an unlawful repudiation within the meaning of Section 8(a)(5) and (1). See *Indiana & Michigan Electric Co.*, 284 NLRB 53 and cases cited at 59 (1987).

Having made the above findings, it is unnecessary to again determine whether the language of the collective-bargaining contract requires Respondent to pay 100 percent of any premium charged by the insurance company or whether it limits the amount to be paid to that set by the insurance company during the 1987-1988 insurance year. The Board, in the earlier case, determined that the Union's argument over contract interpretation was the better and observed that Respondent's argument was not even available insofar as the dental insurance was concerned. Even so, it is not necessary to follow that track here. While the facts are somewhat similar to the previous case, they more strongly support a finding of offer, acceptance and disavowal. It is also unnecessary to determine if the doctrine of promissory estoppel should be invoked.

THE REMEDY

Having found Respondent to have engaged in certain violations of Section 8(a)(5) and (1) of the Act, I shall recommend that it be ordered to cease and desist therefrom and to take certain affirmative action designed to effectuate the policies of the Act. In addition, it shall be ordered to make whole, with interest, those employees for whom it unlawfully deducted from their paychecks moneys used to pay health and dental insurance premiums. In this regard, interest shall be paid in accordance with *New Horizons for the Retarded*, 283 NLRB 1173 (1987). Since this benefit involves term health and dental insurance, rather than an ongoing savings or pension plan no order under *Ogle Protection Service*, 183 NLRB 682 (1970), is required. However, if any employee was deprived of those coverages for failing to pay the increase, he or she (or his/her family if that coverage had been chosen) shall be reimbursed for out-of-pocket expenses incurred. Otherwise, Respondent shall pay the exact amounts deducted or separately paid plus interest.

Upon the foregoing findings of fact and upon the entire record in this case, I make the following

CONCLUSION OF LAW

By refusing to pay the agreed-upon health and dental insurance premium increases and by unilaterally and without negotiating with the Union regarding the manner in which they were to be paid, Respondent has engaged in unfair labor practices affecting commerce within the meaning of Section 8(a)(5) and (1) and Section 2(6) and (7) of the Act.

[Recommended Order omitted from publication.]